



## Testimony

Before the Committee on Veterans'  
Affairs, House of Representatives

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For Release on Delivery  
Expected at 10:15 a.m. ET  
Wednesday, June 18, 2014

# VA HEALTH CARE

## Further Action Needed to Address Weaknesses in Management and Oversight of Non-VA Medical Care

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Report Documentation Page				Form Approved OMB No. 0704-0188	
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1. REPORT DATE <b>18 JUN 2014</b>		2. REPORT TYPE		3. DATES COVERED <b>00-00-2014 to 00-00-2014</b>	
4. TITLE AND SUBTITLE <b>VA Health Care: Further Action Needed to Address Weaknesses in Management and Oversight of Non-VA Medical Care</b>				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) <b>U.S. Government Accountability Office, 441 G Street NW, Washington, DC, 20548</b>				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT <b>Approved for public release; distribution unlimited</b>					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT <b>Same as Report (SAR)</b>	18. NUMBER OF PAGES <b>22</b>	19a. NAME OF RESPONSIBLE PERSON
a. REPORT <b>unclassified</b>	b. ABSTRACT <b>unclassified</b>	c. THIS PAGE <b>unclassified</b>			

# GAO Highlights

Highlights of [GAO-14-696T](#), a testimony before the Committee on Veterans' Affairs, House of Representatives

## Why GAO Did This Study

Due to serious and longstanding problems with the timely scheduling of veterans' appointments in VA facilities, VA recently announced that it will allow additional veterans to be treated through its Non-VA Medical Care Program.

This testimony is based on two GAO reports and addresses the extent to which (1) VA collects reliable information on wait times and cost-effectiveness of the Non-VA Medical Care Program; (2) VA facilities comply with Millennium Act claims processing requirements and VA oversees claims processing activities; and (3) VA educates veterans about eligibility for Millennium Act emergency care and communicates with non-VA providers. For both reports, GAO reviewed relevant requirements and visited 10 VA facilities. For its report on the oversight and management of the Non-VA Medical Care Program, GAO reviewed non-VA medical care spending and utilization data from fiscal year 2008 through fiscal year 2012. For its report on the Millennium Act emergency care benefit, GAO reviewed 128 denied Millennium Act claims to determine the accuracy of processing decisions.

GAO made numerous recommendations to VA in the two prior reports related to improving (1) data on wait times and cost-effectiveness for non-VA medical care; (2) compliance with claims processing requirements; and (3) veterans' knowledge of non-VA medical care eligibility. VA agreed with these recommendations but has yet to fully implement them.

View [GAO-14-696T](#). For more information, contact Randall Williamson at (202) 512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov).

June 18, 2014

## VA HEALTH CARE

### Further Action Needed to Address Weaknesses in Management and Oversight of Non-VA Medical Care

## What GAO Found

GAO's May 2013 report on the oversight and management of the Non-VA Medical Care Program found that the Department of Veterans Affairs (VA) does not collect data on wait times veterans face in obtaining care from non-VA providers. The lack of data on wait times limits VA's efforts to effectively oversee the Non-VA Medical Care Program because it is not possible for VA to determine if veterans who receive care from non-VA providers are receiving that care sooner than they would in VA facilities. In addition, GAO found that VA cannot assess the cost-effectiveness of non-VA medical care because it cannot analyze data on all services and charges for an episode of care, which is a combined total of all care provided to a veteran during a single office visit or inpatient stay. As a result, VA cannot determine whether delivering care through non-VA providers is more cost-effective than augmenting its own capacity in areas with high utilization of non-VA medical care.

GAO's March 2014 report found patterns of noncompliance with applicable requirements for processing emergency care claims covered under the Veterans Millennium Health Care and Benefits Act (Millennium Act) at each of the four VA facilities visited. This led to the inappropriate denial of some claims and the failure to notify veterans that their claims had been denied at these facilities. The Millennium Act authorizes VA to cover emergency care for conditions not related to veterans' service-connected disabilities when veterans who have no other health plan coverage receive care at non-VA providers and meet other specified criteria. Specifically, GAO determined that about 20 percent of the 128 claims it reviewed had been denied inappropriately, and almost 65 percent of the reviewed claims lacked documentation showing that the veterans were informed their claims were denied and explained their appeal rights. As a result of GAO's review, the VA facilities reconsidered and paid 25 claims that they initially had inappropriately denied. GAO also found that there is significant risk that these patterns of noncompliance will continue because VA's existing oversight mechanisms do not focus on whether VA facilities appropriately approve or deny non-VA medical care claims or fail to notify veterans that their claims have been denied.

GAO also reported in March 2014 that gaps exist in veterans' knowledge about eligibility criteria for Millennium Act emergency care, and communication weaknesses exist between VA and non-VA providers. Specifically, GAO found that veterans' lack of understanding about their emergency care benefits under the Millennium Act presents risks for potentially negative effects on veterans' health because they may forgo treatment at non-VA providers, and on veterans' finances because they may assume VA will pay for care in situations that do not meet VA criteria. Despite VA's efforts to improve communications, some non-VA providers reported instances in which VA facilities' claims processing staff were unresponsive to their questions about submitted claims.

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Chairman Miller, Ranking Member Michaud, and Members of the Committee:

I am pleased to be here today to discuss our work on the Department of Veterans Affairs' (VA) delivery of care through its Non-VA Medical Care Program.<sup>1</sup> The majority of veterans enrolled in the VA health care system receive care in VA-operated medical facilities, such as VA medical centers and community-based outpatient clinics.<sup>2</sup> However, VA is authorized to obtain health care services from non-VA providers to help ensure that veterans are provided timely and accessible care.<sup>3</sup> For example, VA may utilize non-VA medical care when a VA facility is unable to provide certain specialty care services, such as cardiology or orthopedics, or when a veteran would have to travel long distances to obtain care at a VA medical facility. Non-VA providers treat veterans in non-VA facilities, such as physicians' offices or hospitals in the community. Non-VA providers are commonly paid by VA using a fee-for-service arrangement. In fiscal year 2013, VA spent about \$4.8 billion on non-VA medical care for more than 1 million veterans, which accounted for about 11.6 percent of VA's total medical services budget for that year.<sup>4</sup>

There are two main non-VA medical care delivery methods—preauthorized care and emergency care—that are approved using two different processes. The first, preauthorized care, is approved in advance by VA facility officials. VA may authorize veterans to seek care from non-VA providers for a number of reasons, including when (1) wait times for appointments at VA facilities exceed VA standards; (2) the distance veterans must travel to VA facilities is impractical for the veteran; and (3) VA facilities do not offer the medical services the veteran needs. Preauthorized care accounts for the majority of spending and utilization

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<sup>1</sup>The Non-VA Medical Care Program was previously known as the Fee Basis Care Program.

<sup>2</sup>VA's health care system includes 151 VA medical centers. VA also provides care to veterans in VA-operated community-based outpatient clinics, community living centers (nursing homes), residential rehabilitation treatment programs, and comprehensive home care programs.

<sup>3</sup>VA obtains the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153.

<sup>4</sup>This percentage reflects final appropriations numbers for VA's total medical services budget after the across-the-board budget rescissions in fiscal year 2013.

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(about 60 percent of spending and about 88 percent of utilization) for the Non-VA Medical Care Program. The second, emergency care, is not typically approved in advance by VA facility officials and has certain criteria that must be met in order for VA to approve reimbursement for the non-VA provider.

In response to serious and longstanding problems regarding the timely scheduling of veterans' appointments in VA facilities that have been highlighted in recent congressional oversight hearings, VA has announced its intention to allow additional veterans to be treated through its Non-VA Medical Care Program. With this likely increase in the utilization of non-VA medical care, it is not only important to ensure that veterans will obtain timely treatment from non-VA providers, but also to ensure that non-VA medical care is a reliable and cost-effective means for VA to deliver services. Today, I will address the extent to which (1) VA collects reliable information on wait times and cost-effectiveness of the Non-VA Medical Care Program; (2) VA facilities comply with claims processing requirements for emergency care provided under the Veterans Millennium Health Care and Benefits Act (Millennium Act), and the extent to which VA oversees facilities' claims processing activities; and (3) VA educates veterans about eligibility for Millennium Act emergency care and communicates with non-VA providers about claims processing.<sup>5</sup>

My statement is based on the key findings of two GAO reports that identified weaknesses in VA's management and oversight of its Non-VA Medical Care Program: a March 2014 report entitled *VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit*, and a May 2013 report entitled *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*.<sup>6</sup> For the March 2014 report, which focused on VA's

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<sup>5</sup>The Veterans Millennium Health Care and Benefits Act (Millennium Act) authorizes VA to cover emergency care for conditions not related to veterans' service-connected disabilities when veterans who have no other health plan coverage receive care at non-VA providers and meet other eligibility criteria. See Pub. L. No. 106-117, § 111, 113 Stat. 1545, 1553 (1999) (codified, as amended, at 38 U.S.C. § 1725).

<sup>6</sup>See GAO, *VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit*, [GAO-14-175](#) (Washington, D.C.: Mar. 6, 2014) and *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*, [GAO-13-441](#) (Washington, D.C.: May 31, 2013).

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administration and oversight of Millennium Act emergency care delivered to veterans by non-VA providers, we reviewed the law, its implementing regulations, and applicable VA policies and guidance to identify applicable requirements for processing these claims. We then visited four VA facilities that were selected on the basis of fiscal year 2012 spending totals and geographic location and reviewed VA documents—including 128 Millennium Act emergency care claims that these four facilities had denied in fiscal year 2012. We also interviewed officials from VA, non-VA providers, and veterans service organizations. For the May 2013 report, which focused on VA’s management and oversight of non-VA medical care spending and utilization, we reviewed relevant laws and regulations, VA policies, and spending and utilization data on non-VA medical care from fiscal years 2008 through 2012. We also interviewed VA officials and examined the non-VA medical care operations at six selected VA facilities that varied in size, services offered, and geographic location. The results of both of these studies cannot be generalized to all VA facilities, but they illustrate the serious weaknesses in various aspects of the Non-VA Medical Care Program. We have made numerous recommendations to VA in these previous reports, and VA has concurred with all of them. We are not making any new recommendations at this time. In June 2014, in preparation for this statement, we met with VA officials to discuss the status of VA’s implementation of action plans to address the recommendations included in these two reports.

The work this statement is based on was conducted in accordance with generally accepted government accounting standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The reports cited provide additional information on our scope and methodology.

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## Background

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### Types of Non-VA Medical Care

When veterans obtain care from non-VA providers, the non-VA providers submit claims to VA for payment. See table 1 for a description of the types of non-VA medical care claims processed by VA.

**Table 1: Types of Non-VA Medical Care Claims and Relevant Payment Authority**

Type of claim	Description and relevant payment authority
Preauthorized care <sup>a</sup>	Services with prior VA authorization meeting criteria under 38 U.S.C. § 1703 (e.g., cancer treatment, mammography)
Emergency care	Services without VA preauthorization (e.g., heart attack care, treatment of injuries from a motor vehicle crash)
Veterans Millennium Health Care and Benefits Act (emergency care for conditions not related to service-connected disabilities)	Services meeting criteria under 38 U.S.C. § 1725
Emergency care for conditions related to service-connected disabilities	Services meeting criteria under 38 U.S.C. § 1728

Source: GAO analysis of VA policies. | GAO-14-696T.

<sup>a</sup>In certain circumstances, emergency care provided by non-VA providers can be deemed preauthorized if the non-VA providers provide notification of a veteran's admission within 72 hours. Emergency care by non-VA providers may also be preauthorized for veterans receiving medical services in a VA facility or nursing home up to the point that the veteran can be safely returned to the VA facility following the emergency care treatment at the non-VA provider.

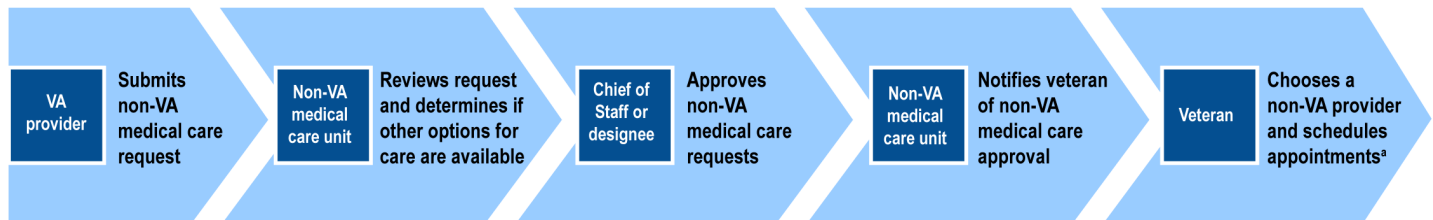
## Preauthorization Process for Non-VA Medical Care

Preauthorizing non-VA medical care involves a multistep process conducted by the VA facility that regularly serves a veteran.<sup>7</sup> The preauthorization process is initiated by a VA provider who submits a request for non-VA medical care to the VA facility's non-VA medical care unit, which is an administrative department within each VA facility that processes VA providers' non-VA medical care requests and verifies that non-VA medical care is necessary. Once approved by the VA facility's Chief of Staff or his or her designee, the veteran is notified of the approval and can choose any non-VA provider willing to accept VA payment at predetermined rates.<sup>8</sup> (See fig. 1.)

<sup>7</sup>VA uses this same preauthorization process for nonemergency inpatient and outpatient care, dental care, nursing home care, compensation and pension exams, and most pharmacy expenses paid for through the Non-VA Medical Care Program.

<sup>8</sup>VA uses this process to preauthorize non-VA medical care from a number of different types of non-VA providers, including community-based hospitals and Department of Defense medical facilities that collaborate with VA facilities to provide some veterans' care.

Figure 1: VA Facility Process for Preauthorizing Non-VA Medical Care



Source: GAO. | GAO-14-696T

<sup>a</sup>In some VA facilities the non-VA medical care unit may assist veterans in setting up their appointments with the non-VA provider of their choice.

## Criteria for VA Coverage of Emergency Care from Non-VA Providers

For claims that are emergent in nature and therefore would not have gone through the traditional VA preauthorization process, VA is authorized to pay claims for emergency care from non-VA providers under certain conditions, which vary depending on whether the care was related to the veteran's service-connected disability.

If a non-VA emergency care claim is related to a veteran's service-connected disability, the following criteria must be met in order for the services to be paid for by VA.

- First, the non-VA emergency care must have been rendered to treat one of the following: (a) a veteran's service-connected disability; (b) a condition that is associated with and aggravating the veteran's service-connected disability; (c) any condition for a veteran who has been rated by VA as permanently and totally disabled due to a service-connected disability; or (d) any condition for a veteran participating in a vocational rehabilitation program who needs care to participate in a course of training.
- Second, the non-VA emergency care must also meet all of these criteria:
  - the claim must be filed within 2 years of the date the care or services were rendered;

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- the services were rendered in a medical emergency, as determined using the prudent layperson standard;<sup>9</sup>
  - a VA or other federal facility was not feasibly available to provide the needed care, and an attempt to use either would not have been considered reasonable; and
  - the services were needed before the veteran was stable enough to be transferred to a VA or other federal facility and before the VA or other federal facility agreed to accept the transfer.

If a claim for non-VA emergency care is not related to a veteran's service-connected disability, there are different criteria that must be met in order for the services to be paid for by VA. The Millennium Act, which was enacted in 1999, provides a safety net for veterans when they do not have other insurance and need emergency care that is not related to a service-connected disability. Specifically, all of the following criteria must be met for VA to cover Millennium Act claims:

- The claim is not payable under the payment authority for emergency care related to service-connected disabilities.
- The claim must be filed within 90 days of the latest of the following: the date of discharge, date of death, or date that the veteran exhausted, without success, action to obtain payment or reimbursement from a third party.
- The veteran must be enrolled in the VA health care system and have received treatment from a VA clinician within 24 months of the emergency care episode.
- The veteran must be financially liable to the non-VA provider of emergency care.

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<sup>9</sup>A medical emergency exists when the condition is of such a nature that a prudent layperson would reasonably expect that delay in seeking immediate medical attention would be hazardous to life or health. The standard would be met if there was an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. See 38 C.F.R. § 17.1002(b). The prudent layperson standard emphasizes the patient's presenting symptoms, rather than the final diagnosis, when determining whether to pay emergency medical claims.

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- The veteran can have no entitlement to care under a health plan contract (such as Medicare or a private health insurance plan).<sup>10</sup>
  - The veteran can have no other contractual or legal recourse against a third party that would in whole extinguish his or her liability to the non-VA provider.<sup>11</sup>
  - The services must be rendered in a hospital emergency department or a similar facility providing emergency care to the public.
  - The services must be rendered in a medical emergency as determined using the prudent layperson standard.<sup>12</sup>
  - A VA or other federal facility was not feasibly available to provide the needed care, and an attempt to use either would not have been considered reasonable by a prudent layperson.
  - The services were rendered before the veteran was stable enough to be transferred to a VA or other federal facility and before the VA or other federal facility agreed to accept the transfer.

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## Process for Paying Non-VA Medical Care Claims

Regardless of whether a veteran's non-VA medical care was preauthorized or the result of an emergency, the steps for processing payments to non-VA providers are the same. Specifically, the non-VA provider submits a claim to either a Veterans Integrated Service Network (VISN) or a VA facility for payment following the veteran's treatment.<sup>13</sup> In some VISNs, claims processing activities are centralized in a VISN-level department that is responsible for reviewing claims from non-VA providers, obtaining copies of medical records for veterans' non-VA medical care, and approving payment to non-VA providers. In other

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<sup>10</sup>The 2010 amendments to the Millennium Act changed the definition of a health plan contract to exclude state laws requiring motor vehicle drivers to have auto insurance as a source of coverage. Act of Feb. 1, 2010, Pub. L. No. 111-137, §1(a)(2), 123 Stat. 3495.

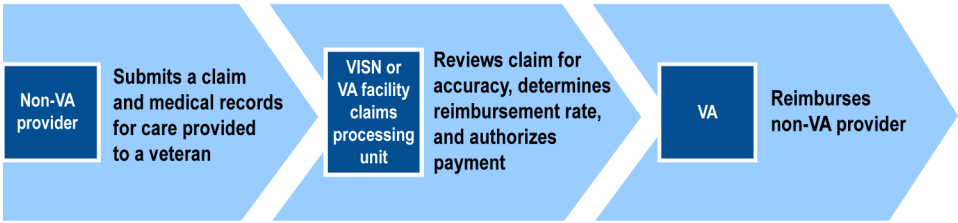
<sup>11</sup>The 2010 amendments to the Millennium Act also authorized VA to pay for treatment when a veteran has recourse against a third party for a portion, but not all, of the veteran's liability. In such cases, VA becomes the secondary payer, such as when auto insurance only partly covers the veteran's liability to the non-VA provider.

<sup>12</sup>38 C.F.R. § 17.1002(b).

<sup>13</sup>VA's health care system is divided into 21 areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area. VISNs oversee the day-to-day functions of VA facilities that are within their network. Each VA facility is assigned to a single VISN.

VISNs, these claims-processing activities are decentralized and are the responsibility of individual VA facilities. After VA facility or VISN officials review the claims for accuracy, non-VA providers are reimbursed by VA. (See fig. 2.)

**Figure 2: Veterans Integrated Service Network (VISN) or VA Facility Steps for Processing Approved Claims for Non-VA Medical Care**



Source: GAO. | GAO-14-696T

To process all claims for non-VA medical care, VA facilities use software called the Fee Basis Claims System (FBCS).<sup>14</sup> FBCS is primarily a system that helps VA facilities administer payments to non-VA providers, as opposed to a system that automatically applies relevant criteria and determines whether claims are eligible for payment. As a result, VA relies on staff in the VISNs and VA facilities that process claims, such as administrative clerks and clinicians (typically nurses), to make decisions about which payment authority applies to the claim and which claims meet the criteria for VA payment.

**Notifying Veterans and Non-VA Providers of Denials of Claims for Non-VA Medical Care**

If VA denies payment for a claim for non-VA medical care, the Department must provide written notice to the veteran and the claimant (usually, the non-VA provider) regarding the reason for the denial and inform them of their rights to request a reconsideration or to formally appeal the denial. If a veteran or non-VA provider has questions about a denied claim, claims should be reconsidered by a supervisor at the same VISN or VA facility that denied the claim. If the denial decision is upheld,

<sup>14</sup>The Non-VA Medical Care Program was previously known as the Fee Basis Care Program.

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the veteran or non-VA provider has the right to file an appeal through the Board of Veterans' Appeals.<sup>15</sup>

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## VA Lacks Critical Data on Wait Times and Cost-Effectiveness of Non-VA Medical Care

Critical data limitations related to the wait times veterans face in obtaining care from non-VA providers and the cost-effectiveness of such services limit VA's efforts to oversee the Non-VA Medical Care Program in an effective manner. Most notably, VA does not collect data on how long veterans must wait to be seen by non-VA providers. We previously reported that the amount of time veterans wait for appointments in VA facilities influenced VA's utilization of non-VA medical care. For example, in our May 2013 report, VA officials from all six facilities we reviewed reported that they routinely referred veterans to non-VA providers to help ensure that veterans receive timely care and their facilities meet performance goals for wait times for VA facility-based care.<sup>16</sup> Officials from one of these VA facilities explained that veterans needing treatment in several specialties—including audiology, cardiology, and ophthalmology—were referred to non-VA providers for this reason.

In fiscal year 2012, VA performance goals for wait times for care in VA facilities called for veterans' primary care appointments to be completed within 7 days of their desired appointment date and veterans' specialty care appointments to be scheduled within 14 days of their desired appointment date. However, since VA did not track wait times for non-VA providers, little was known about how often veterans' wait times for non-VA medical care appointments exceeded VA facility-based appointment wait time goals. Officials from one VA facility we reviewed explained that non-VA providers in their community also faced capacity limitations and may not be able to schedule appointments for veterans any sooner than the VA facility.

Limitations in the way VA collects non-VA medical care data also did not allow the Department to analyze the cost-effectiveness of non-VA medical care provided to veterans. In our May 2013 report, we found that VA

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<sup>15</sup>Based in Washington, D.C., the Board of Veterans' Appeals is composed of judges experienced in veterans' law. The Board reviews benefit determinations made by local VA offices and issues final decisions on appeals.

<sup>16</sup>See [GAO-13-441](#). These six facilities were located in Durham and Salisbury, North Carolina; Alexandria, Louisiana; Biloxi, Mississippi; Las Vegas, Nevada; and Loma Linda, California.

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lacked a data system to group medical care delivered by non-VA providers by episode of care—a combined total of all care provided to a veteran during a single office visit or inpatient stay.<sup>17</sup> For example, during an office visit to an orthopedic surgeon for a joint replacement evaluation, an X-ray for the affected joint may be ordered, the veteran may be given a blood test, and the veteran may receive a physical evaluation from the orthopedic surgeon. The non-VA provider would submit a claim to VA for the office visit, and separate claims would be submitted by the radiologist that X-rayed the affected joint and the lab that performed the veteran's blood test. However, VA's non-VA medical care data system was not able to link the charges for these three treatments together. We found that this left VA without data for comparing the total non-VA medical care costs for various types of services with the VA facility-based alternative.

Without cost-effectiveness data, VA is unable to efficiently compare VA and non-VA options for delivering care in areas with high utilization and spending for non-VA medical care. Two VA facilities we reviewed had undertaken such assessments, despite the limitations of current data. Officials at one facility reported that they expanded their operating room capacity to reduce their reliance on non-VA surgical services, saving an estimated \$18 million annually in non-VA medical care costs. Similarly, officials from the second facility reported that they were able to reduce their reliance on non-VA medical care by hiring additional VA staff and purchasing additional equipment to perform pulmonary function tests, an effort that reduced related non-VA medical care costs by about \$112,000 between fiscal years 2010 and 2012. The lack of non-VA medical care data available on an episode of care basis also prevents VA from efficiently assessing the appropriateness of non-VA provider reimbursement. Specifically, VA officials cannot conduct retrospective reviews of VA facilities' claims to determine if the appropriate rate was applied for the care provided by non-VA providers.

To help VA address these concerns, we made two recommendations in our May 2013 report that directed VA to (1) analyze the amount of time

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<sup>17</sup>In March 2013, VA officials told us that for inpatient claims they could construct a program to group inpatient and inpatient ancillary claims together by linking all the records of individual services provided to veterans during a particular date range. However, this method relies on correct data entry by VISNs and VA facilities into FBCS and correct information to be furnished by non-VA providers. VA officials acknowledged that there is no way to link outpatient services together to create a record of a single outpatient episode of care.

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veterans wait to see non-VA providers and apply the same wait time goals to non-VA medical care that have been used to assess VA facility-based wait times, and (2) establish a mechanism for analyzing the episode of care costs for non-VA medical care. VA concurred with these recommendations. In June 2014, we discussed VA's progress in implementing these recommendations with VA officials. These officials indicated that the Department anticipated being able to track some wait time information for veterans seen by non-VA providers that VA contracts with under its new Patient Centered Community Care (PCCC) initiative in the near term.<sup>18</sup> However, wait time information for all non-VA medical care will not be readily available until VA completes a redesign of its claims processing system, which is expected to occur in fiscal year 2016. With respect to establishing a mechanism to analyze the episode of care costs for non-VA medical care, VA officials explained that they are in the process of fully implementing this recommendation by (1) improving existing data systems to systematically audit claims that include billing codes typically included in bundled payments while the claims are in a pre-payment status and to require VA facilities to review these claims prior to payment, and by (2) making improvements to its Non-VA Medical Care Program data that would allow all non-VA medical care data to be analyzed on an episode of care basis. However, VA officials did not provide a time frame for when all non-VA medical care would be routinely analyzed by episode of care.

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<sup>18</sup>Under PCCC, VA facilities have the ability to purchase non-VA medical care through contracted non-VA providers when they cannot readily provide the needed care due to geographic inaccessibility or limited capacity. VA has awarded two PCCC contracts, one to Health Net Federal Services, LLC, and another to TriWest Health Alliance Corporation. Under these contracts, these companies are setting up networks in six regions covering the entire country.

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## Selected VA Facilities Failed to Comply with Applicable Millennium Act Claims Processing Requirements, and Weaknesses Were Identified in VA's Oversight of Claims Processing Activities

In March 2014, we reported that four VA facilities we visited had patterns of noncompliance with VA claims processing requirements, which led to the inappropriate denial of some Millennium Act emergency care claims and the failure to notify some veterans that their claims had been denied.<sup>19</sup> We also found that VA's existing oversight mechanisms for non-VA medical care claims processing were not sufficiently focused on whether VA facilities were inappropriately approving or denying claims.

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## Selected VA Facilities Frequently Did Not Comply with Claims Processing Requirements, Which Led to the Inappropriate Denial of Claims

For our March 2014 report, we examined a sample of 128 Millennium Act emergency care claims that the four VA facilities we visited had denied in fiscal year 2012 and found 66 instances of noncompliance with VA policy requirements. We determined that about 20 percent of the claims we examined had been denied inappropriately, and almost 65 percent of the claims we examined lacked documentation showing that the veteran was notified that their claim was denied. As a result of our review, these four VA facilities reconsidered and paid 25 claims that they had inappropriately denied.

We found that there are no automated processes for determining whether a claim for non-VA medical care meets criteria for payment or ensuring that veterans are notified when a claim is denied; instead these processes rely on the judgment of VA staff reviewing each claim and adherence to VA policies. There are a number of steps in the claims review process that were susceptible to errors that could lead to inappropriate denials of non-VA medical care claims. For example, we found nine instances where VA staff incorrectly determined that non-VA medical care was not preauthorized when, in fact, a VA clinician had

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<sup>19</sup>See [GAO-14-175](#). We visited the North Texas VA Health Care System; the Washington, D.C., VA medical center; the White River Junction VA medical center; and the Black Hills VA Health Care System.

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referred the veteran to the non-VA provider.<sup>20</sup> In addition, VA policy states that VA must notify veterans in writing about denied claims and their appeal rights. However, we found that one facility we visited could not produce documentation of veteran notification for any of the 30 denied claims we reviewed. We concluded that when veterans are not informed that their claims for non-VA medical care have been denied, and VA has inappropriately denied the claims, then veterans could become financially liable for care that VA should have covered. Under such circumstances, veterans' credit ratings may be negatively affected, and they may face personal financial hardships if they are unable to pay the bills they receive from non-VA providers.

These findings from our March 2014 report raise concerns about compliance with claims processing requirements at other VA facilities nationwide. To help VA address these concerns, we made six recommendations aimed at improving VA's processing of non-VA medical care claims, specifically Millennium Act emergency care claims. These recommendations directed the Department to establish or clarify its policies or take other actions to improve VA facilities' compliance with existing policy requirements. VA concurred with these six recommendations. Based on discussions with VA officials in June 2014 to obtain information about the status of their planned actions for implementing these recommendations, we believe that VA is making progress on the implementation of three of the six recommendations. However, VA needs to take additional steps to revise its policies on claims processing roles and responsibilities in order to address our remaining three recommendations.

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### Weaknesses Found in VA's Oversight of Non-VA Medical Care Claims Processing

One of VA's primary methods for monitoring its facilities' compliance with applicable requirements for processing non-VA medical care claims is field assistance visits. In fiscal year 2013, VA conducted these visits at 30 out of 140 VA facilities that processed non-VA medical care claims. These 30 facilities were selected for review by VA based on their claims

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<sup>20</sup>In eight of these nine instances, VA clinicians did not properly document their referrals in VA's electronic medical record, as required by VA policy. As a result, non-VA medical care unit staff were not alerted to create authorizations in FBCS, which is a necessary step for the payment of preauthorized non-VA medical care claims. In the remaining instance, staff who processed the claim did not have access to any authorizations in FBCS that had been issued by other VA facilities and did not know that a VA clinician from a different VA facility had referred the veteran to the non-VA provider.

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processing timeliness. However, we reported in March 2014 that the criteria VA used to select facilities for review may not direct VA to the facilities most in need of a field assistance visit because VA does not take into account the accuracy of claims processing activity. Moreover, we found that the checklist VA uses for its field assistance visits does not examine all practices that could lead VA facilities to inappropriately deny claims.<sup>21</sup> Further, VA does not hold facilities accountable for correcting deficiencies identified during these visits, and it does not validate facilities' self-reported corrections to address field assistance visit deficiencies. According to VA officials, these visits are meant to be consultative in nature and assist facilities in improving their non-VA medical care claims processing. However, we found weaknesses in VA's reliance on facilities' self-reported actions when we reviewed the Department's fiscal year 2012 and 2013 field assistance visit data and found unresolved problems in fiscal year 2013 that originated in fiscal year 2012.<sup>22</sup>

Further, VA implemented automated processes for auditing approved non-VA medical care claims to ensure that VA facilities apply the correct payment rates and no duplicate versions of the claims were previously paid. However, VA has no systematic process for auditing claims to ensure that they were appropriately approved or denied. VA officials stated that they recommend, but do not require, that managers of non-VA medical care claims processing units at VA facilities audit samples of processed claims—including both approved and denied claims—to determine whether staff processed claims appropriately. However, we found that VA does not know how many facilities conduct such audits, and none of the four VA facilities we visited reported conducting such audits.

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<sup>21</sup>For example, VA's checklist does not examine VA facilities' practices for determining whether veterans are enrolled at a different VA facility and whether they have been seen by providers at another VA facility in the last 24 months—a critical criteria for determining whether veterans are eligible for Millennium Act emergency care coverage.

<sup>22</sup>For example, when we reviewed these data, we found that one VA facility had been cited in fiscal year 2012 because it was not entering authorizations for referrals to non-VA providers in a timely fashion into FBCS—a practice that could lead to the inappropriate denial of claims. When we reviewed VA's fiscal year 2013 field assistance visit data for this facility, we noted that VA observed this same deficiency again that year, even though facility officials had reported after the previous year's visit that the problem had been resolved.

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In our March 2014 report, we concluded that ensuring VA facilities correct deficiencies identified during field assistance visits and conduct systematic audits of the accuracy of claims processing decisions would provide necessary transparency and stability to the Non-VA Medical Care Program. To help VA address these issues, we made three recommendations aimed at revising the scope of the field assistance visits, ensuring deficiencies identified during these visits are corrected, and instituting systematic audits of the appropriateness of claims processing decisions. VA concurred with these recommendations and detailed its plans to address them. In June 2014, VA officials detailed the Department's progress implementing these recommendations. However, we do not believe the Department's actions have sufficiently addressed these recommendations. To fully implement these three recommendations, VA needs to ensure field assistance visits include a review of a sample of processed claims in order to determine whether staff are complying with applicable requirements for claims processing and needs to establish systematic audits of claims processing decisions, among other things.

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## Veterans Lack Knowledge about Millennium Act Emergency Care Eligibility, and Selected Non-VA Providers Have Reported Communication Challenges with VA

In March 2014, we found that despite VA's communication efforts with veterans and non-VA providers, knowledge gaps exist for veterans about eligibility for Millennium Act emergency care, and communication weaknesses exist between VA and non-VA providers.<sup>23</sup>

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<sup>23</sup>[GAO-14-175](#).

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## Veterans Lack Knowledge about Eligibility for Coverage of Millennium Act Emergency Care

In March 2014, we reported that veterans may still be unaware of the criteria that must be met in order for VA to pay claims for non-VA medical care; specifically, Millennium Act emergency care. VA primarily educates veterans about their eligibility for non-VA medical care through patient orientation sessions and written materials, such as the Veteran Health Benefits Handbook. However, VA patient benefits and enrollment officials at two of the four VA facilities we visited said that patient orientation sessions were generally not well-attended. Also, written materials we reviewed did not always provide a complete listing of all criteria that must be met for Millennium Act emergency care claims to be covered, which may create confusion about whether veterans should seek treatment from a VA facility or a non-VA provider in the event of an emergency. VA officials said that the primary intent of the written materials was to communicate the importance of promptly seeking care and to discourage veterans from delaying care by bypassing non-VA providers in the event of an emergency. However, some VA officials acknowledged that they were aware of specific recent cases where veterans delayed or avoided seeking treatment at non-VA providers to go to a VA facility instead. For example,

- one VA official explained that a veteran experiencing chest pains drove over 100 miles to a VA facility rather than going to the nearest emergency department;
- two VA officials said the wife of a veteran who had gunshot wounds drove him to a VA facility about 30 miles away, bypassing a number of non-VA emergency departments; and
- another VA official explained that a veteran experiencing chest pains died during a weekend as he waited to seek care until the local VA community-based outpatient clinic opened on Monday.

Alternatively, we found that without knowledge of specific criteria for VA payment of non-VA medical care, specifically Millennium Act emergency care, veterans may seek treatment in situations where the Department cannot pay. For example, veterans may seek care at a non-VA provider for conditions they believe require immediate attention—such as one for which they have not been able to obtain timely treatment from a VA facility. However, VA staff reviewing the claim may decide that the condition does not meet the prudent layperson standard for emergency care and deny payment. Veterans that are admitted as inpatients to non-VA providers also may not be aware that they should be transferred to VA facilities once their conditions have stabilized and a VA facility has

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notified the non-VA provider that a bed is available for their care at the VA facility.

To help VA address concerns about veterans' lack of knowledge of non-VA medical care—specifically, Millennium Act emergency care—we recommended in March 2014 that VA take steps to better understand gaps in veterans' knowledge regarding eligibility for non-VA coverage by surveying them about their health care benefits knowledge and using information from those surveys to tailor the Department's veteran education efforts. While VA concurred with this recommendation, in June 2014 VA officials indicated that the Department has decided not to pursue veteran surveys but instead will promote veteran education by appearing at conferences and town halls with veterans service organizations and updating the information on its public website. We remain concerned that, without surveying veterans directly, VA will not be able to identify specific veteran knowledge gaps regarding coverage of non-VA medical care or determine ways to better target VA's veteran education efforts.

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#### Non-VA Providers Reported Communication Problems with VA

For our March 2014 report, all four non-VA providers we visited cited problems in their non-VA medical care claims processing communication with VA regarding the following issues:

- **Points-of-contact not designated.** Two of the four non-VA providers said they did not have a specific point-of-contact at their VA facilities who could answer concerns and issues about claims they had submitted, which led to problems resolving their issues in a timely manner.
- **Delays in claims processing.** Billing officials at one non-VA provider described lengthy delays in the processing of their claims, which in some cases went on for years.
- **Lack of responsiveness when trying to transfer veterans and failure to document discussions about potential transfers.** Officials at one non-VA provider said they had experienced challenges connecting with the inpatient admissions staff at their local VA facility, making it difficult for them to transfer veterans to the VA facility after the veterans were stabilized. According to this provider, the VA facility did not consistently answer calls during business hours or weekends. Officials from a non-VA provider also described cases where they had attempted to transfer stable veterans to the VA facility, but the VA facility informed them that there were no beds available. Later, the VA facility denied these claims because VA could

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find no record of this contact with the non-VA provider or authorizations for continued care.<sup>24</sup>

VA officials said they have attempted to improve communications with non-VA providers. Specifically, they have established a website and electronic newsletter for non-VA providers in order to disseminate information about non-VA medical care requirements. In addition, VA mailed letters to all non-VA providers that had submitted claims during the previous 2 years to inform them of these online resources. However, none of the four non-VA providers included in our March 2014 review recalled receiving the letter that VA mailed. Two non-VA providers were familiar with the website, but one commented that it lacked some necessary information and was not useful. None of these four non-VA providers were aware of VA's electronic newsletter, and VA officials acknowledged that a very small percentage of the non-VA providers who submit claims to VA had signed up for it. While these communications have not always reached their intended audience, VA is continuing its efforts to improve communications with non-VA providers. Specifically, VA has been conducting satisfaction surveys to continue monitoring its communications with non-VA providers and has been holding training sessions for VA staff on improving outreach with non-VA providers.

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Chairman Miller, Ranking Member Michaud, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have.

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## GAO Contact and Staff Acknowledgments

If you or your staffs have any questions about this statement, please contact me at (202) 512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement include Marcia A. Mann, Assistant Director; Emily Beller; Cathleen Hamann; Katherine Nicole Laubacher; Alexis C. MacDonald; and Jennifer Whitworth.

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<sup>24</sup>Unless VA authorizes continued care, it cannot pay for non-VA medical care past the point at which the veteran was medically stable for transfer to a VA facility.

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